Summary of comments from Community Forum

Date of Community Forum: February 12, 2006

Time: 3:00 – 4:00 p.m.

Location: RI Department of Administration, Conference Room A

Individuals who spoke at the Community Forum:

- Annalee Wulfhuhle

- Lisa Smolski

- Greg Mercurio

- Liz Gemski, American Cancer Society – RI Chapter

Individuals who sent written comments:

- Edward F. Almon, Sr., Member, Health Services Council

- Kathleen Connell, AARP – RI Chapter

The Coordinated Health Planning Advisory Committee requested that members of the community present their views on the draft report titled "A Proposal: Coordinated Health Planning in Rhode Island" distributed February 5, 2007.

Summary

Annalee Wulfhuhle:

- Commented that it seems that the Coordinated Health Planning Advisory Committee is thinking of health planning as most

appropriate for aggressive acute care services.

- Asked the Coordinated Health Planning Advisory Committee consider planning for end-of-life needs as well.

- Commented that planning is important from a cost standpoint – i.e., millions of dollars are going towards health treatment that could go to a non-traditional health care setting.

- Planning for end-of-life care would include planning for access, affordability, and quality of those services.

Members of the Advisory Committee asked Ms. Wulfkuhle asked:

Q: Of all the people who would benefit from hospice care, how many people receive hospice care?

A: 35-40%. Most people get additional care first, and then get hospice care. If we could add more palliative care services, we could increase quality and decrease cost of health care.

Q: What is the main barrier to accessing hospice care?

A: Nationwide, physician referral patterns do not advantage hospice care. Physicians are more inclined to different treatment, and might not have the relationship with their patients that makes them comfortable to suggest hospice care. In Rhode Island, people think of it as inpatient care.

Q: If there is greater demand, could workforce respond?

A: Yes. Even though there is a health care worker shortage overall, home and hospice care is growing.

Lisa Smolski

- Applauded the work of the Coordinated Health Planning Advisory Committee.

- Stated that the Committee's stated expectations for the health care system are consistent with all the things that the Rhode Island Free Clinic wants to do for the adult uninsured population.

- Asked the Committee to be mindful of the 120,000 uninsured individuals in Rhode Island, who are often overlooked in planning. The Emergency Rooms of our hospitals are not the place for them to receive care.

- Asked that the uninsured be heard in this process.

Comment from the group: One of the reasons to do health planning is to reallocate resources and make health insurance more affordable.

Greg Mercurio

- Thanked the Committee for their work.

- Commented that he thought more people should know about this process.

- Presented his concerns both as a citizen and as a developer of high-technology radiation therapy center at Roger Williams Hospital, the founder/developer of PET/CT company that offers shared utilization of equipment that brings cutting edge technology to Rhode Island providers. He is a proponent of the Certificate of Need process.

- Pointed out the following:

1. Absent from the report was a discussion of the need for parity between mental health services and physical health services. Suggested that the Committee include mention of the necessity for achieving parity for coverage between mental and physical health care services.

2. There must be coordination between the Dept. of Health activities and other state activities. For example, believes that the 2% surcharge on diagnostic imaging services was inconsistent with this planning process. This surcharge applies to obstetricians and gynecologists and the gross revenues of all providers who do follow-up x-rays. This surcharge penalizes for-profit providers who bring a high standard of technology and services to the state by updating outdated equipment. For-profit providers have the expertise and resources to bring in technology, but they face barriers of higher taxes and the Certificate of Need process. As a result, Rhode Island physicians are building technological services in Massachusetts, and are still being reimbursed by Rhode Island's payers for the procedures they do. This undermines the planning process and shifts the beneficiary of tax revenue from these for-profit businesses from Rhode Island to Massachusetts. The Advisory Committee should be cognizant of this pattern.

3. Currently, there is no incentive for providers to share the use of health care technology and equipment. For example, the MRI Network went out of business. Asked the Committee to think of ways to reward providers who are willing to set up the logistics of a shared

utilization network (like PET/CT network). For example, community hospitals that need PET/CT services could benefit from the existence of mobile networks, but these networks are not rewarded.

Q: With regard to the providers who move out of state, is it due to the 2% surcharge or the Certificate of Need process?

A: Some people don't understand the Certificate of Need process, so it unnecessarily scares them away. However, it has more to do with the payers. For example, you get paid more to do surgery in Massachusetts than in RI.

Liz Gemski:

- Stated that she has been monitoring the Coordinated Health Planning process.

- Commented that goals for prevention are not stated in the plan.

- Commented that preventing disease or catching it early decreases the cost of treatment of the disease, so this point should be highlighted in the plan.

Written comments submitted:

From Ted Almon. President, CEO, Claflin Co. (Feb. 11th 2007 email)

My congratulations to the committee and its leadership on a fair, balanced and insightful plan to implement a much needed planning

process for our State's Health care delivery system. It is apparent from the report that the advisory panel had an understanding of the function of our complex network of purchasers, payers, providers, and consumers, as well as the profoundly dysfunctional aspects of its operation and imminence of crisis.

One can only hope that its recommendations and their implementation come soon enough to avert the failure of the most threatened stakeholders.

Finding little in the substance of the report with which to take issue, one is left to speculate on whether the "solution" proposed to resolve a well-defined problem is optimum. In essence this involves the makeup of the "Health Care Planning and Accountability Council". Such a body will need to be broad enough to allow participation by a truly representative group of stakeholders without becoming too cumbersome to enact decisive action on issues sure to lack complete consensus. Remediation of the current crisis is certain to require an "omelet" of a plan involving the breaking of more than a few eggs, which may well represent the interests of some at the table. My personal observation is that these are most likely to be held by the insurers, who are perhaps over-represented, as compared for example to the hospitals. Clearly the community hospitals have interests disparate from the academic medical centers, which would suggest two CEO's, and why are insurers allowed "designees" when hospitals are not? Perhaps neither should be. Businesses too are insufficiently homogeneous to be represented by a single position.

Small business clearly has interests in healthcare financing significantly different from large, self insured firms. For governance purposes, an "Executive Committee" of perhaps five might provide the most nimble and decisive structure. Such a body could be elected, at least partially, by the group itself.

These observations are merely suggestions, and certainly not criticisms of the report, although at the risk of one too many clichés, the "devil" will most definitely be in the details of the plan, and since the "Council" will hold ultimate accountability for the success of the process, its structure, autonomy, authority, and governance should be most carefully considered as the enabling legislation is conceived.

From Kathleen Connell, State Director, AARP (Feb. 13th 2007 email)

First-----kudos all around on the process and the draft.

AARP strongly urges a re balancing of the recommendation to provide more consumer representation on the HCP&A Council.

The point raised by the gentleman at the Forum to incorporate a parity provision for mental health and physical manifestations of mental illness is worthy of consideration.

Thank you for the opportunity to give some input.